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Authors

Hirschtritt, Matthew
Tahir, Peggy
Kalapatapu, Raj
et al.

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SYSTEMATIC REVIEW

Diversity, Equity and Inclusion

Experiences of transgender and gender diverse patients in emergency psychiatric settings: A scoping review

Megan O'Brien MD[1] | **Matthew E. Hirschtritt MD, MPH**[1,2,3] | **Peggy Tahir MA, MLIS**[4] | **Raj K. Kalapatapu MD, PhD**[1]

[1]Department of Psychiatry and Behavioral Sciences, University of California, San Francisco, USA

[2]Division of Research, Kaiser Permanente Northern California, Oakland, California, USA

[3]Department of Psychiatry, Kaiser Permanente Oakland Medical Center, Oakland, California, USA

[4]Department of Library Sciences, University of California, San Francisco, USA

Correspondence
Raj K. Kalapatapu, MD, PhD, Department of Psychiatry and Behavioral Sciences University of California, San Francisco, 401 Parnassus Avenue, San Francisco, CA 94143, USA.
Email: rajkumar.kalapatapu@ucsf.edu

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Abstract

Objective: This scoping review aims to characterize what is known about transgender and gender diverse (TGD) individuals in emergency psychiatric settings and identify what gaps persist in this literature.

Methods: A search of 4 electronic databases (PubMed, Web of Science, GenderWatch, and PsycINFO) was used for data collection. Included were studies that looked at TGD individuals presenting to a psychiatric emergency department (ED) or ED with a primary mental health concern. Study screening progress was documented in a Preferred Reporting Items for Systematic reviews and Meta-Analyses flow chart. A total of 232 titles and abstracts were screened, 38 full texts were evaluated for eligibility, and 10 studies were included.

Results: The studies reviewed identified mental health vulnerabilities unique to the TGD population, including service denial in health care settings, gender dysphoria, increased rates of non-suicidal self-injury, and in some studies an increase in suicidality. Societal inequities, including the risk of discrimination and residential instability, were also revealed. A subset of the studies identified best practices in caring for this population, including the use of non-judgmental, affirmative, and inclusive language, and on a structural level creating emergency environments that are confidential, inclusive, and therapeutic for these individuals.

Conclusions: There is limited information on TGD individuals in emergency psychiatric settings, and thus it is difficult to form strong conclusions. However, the current evidence available suggests possible inequities in this population. Three major themes with regards to TGD individuals in emergency psychiatric settings were identified: mental health vulnerabilities, societal inequities, and best practices in caring for this population. Overall, there is a scarcity of literature in this field, and further research on the experiences of this population is needed to inform clinical practice.

KEYWORDS
emergency psychiatric services, gender minority, gender nonconforming, mental health, queer, transgender

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1 | INTRODUCTION

1.1 | Background

The terms transgender and gender diverse (TGD) refer to individuals whose gender identity or expression differs from their sex assigned at birth.[1] In the literature on this topic, TGD individuals are sometimes referred to as gender minority individuals. Although we aim to use the term TGD individuals throughout this article, we will occasionally use the term gender minority when discussing the results of an article that used that as the primary term.

An estimated 1.6 million adults and youth, or 0.6% of individuals, identify as transgender in the United States.[2] This number is even greater if including the wider spectrum of gender diversity. TGD individuals are known to be at an increased risk for multiple negative mental health outcomes, including elevated rates of depression, suicidal ideation, and self-harm behaviors.[3] As a result, TGD individuals may present to emergency psychiatric settings during mental health crises. Emergency psychiatric care can be managed in psychiatric emergency departments (EDs); however, many communities do not have specific psychiatric EDs and so psychiatric emergencies and mental health care concerns are managed in the general ED. Although gender diverse individuals only represent a small sample of ED patients, there is a clear need for more support of this population. A study analyzing the Nationwide Emergency Department Sample database from 2006–2018 showed that 28.7% of transgender patients visiting an ED had a mental health condition compared to 2.9% of cisgender patients.[4] Emergency settings are challenging settings for anyone, but research shows that TGD individuals are especially vulnerable.[5] TGD individuals face unique challenges in acute psychiatric care settings, including mis-gendering (use of wrong names and pronouns, etc), issues with privacy, and provider competence in LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and More) health care.[5]

1.2 | Importance

Although systematic reviews are used to synthesize and assess research related to a specific question or questions, scoping reviews can be used to identify gaps in the literature.[6] At present, there is little known about the experiences of TGD individuals in emergency psychiatric settings. As a result, the published literature on this topic is limited and fragmented; therefore, a scoping review is likely to capture the existing literature that addresses this topic better than a more restrictive and structured systematic review.

1.3 | Goals of this investigation

This scoping review explores the existing literature regarding TGD individuals in emergency psychiatric settings. Specifically, this scoping review aims to address the following questions: "What has been published regarding the experiences of TGD individuals in emergency psychiatric settings, and what gaps remain in our understanding of this topic?"

2 | METHODS

2.1 | Study design and registration

The current scoping review followed guidelines described in the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR).[7] Given that this was designed as a scoping review in which we modified and expanded our search strategy based on our initial search results, we did not preregister this scoping review on a publicly available database. This scoping review has no source of funding and is solely the responsibility of the authors.

2.2 | Search strategy

We searched PubMed, Web of Science, GenderWatch, and PsycINFO databases to find articles for our review. Searches were developed to query the literature on the topics of emergency psychiatric services and transgender or gender diverse persons, with multiple synonyms developed for each concept to create sensitive and broad searches. The full search strategies for each database are included as Table S1. The original searches were conducted on July 12, 2022, updated on May 15, 2023, and were run without date or other limiting factors. Our gray literature searches included reviewing the references for the articles selected for data extraction and conducting google searches for white articles, statistics, and other relevant background information. As suggested by the PRISMA-ScR,[7] we used the Peer Review of Electronic Search Strategies (PRESS) Peer Assessment Form[8] to independently peer review our search strategy by another librarian. This completed Peer Assessment Form has been uploaded as Table S2.

2.3 | Selection of studies

To be included in our study, the identified articles studied: (1) individuals who identified as transgender or gender diverse; (2) individuals presenting with a primary psychiatric concern; and (3) individuals in the psychiatric ED or the ED setting. If the location of the study was in the ED, the study needed to mention a primary psychiatric complaint as the reason for the visit. Excluded from our study were articles that studied: (1) only lesbian, gay, bisexual, or heterosexual individuals; or (2) individuals whose psychiatric diagnosis was a secondary diagnosis or whose psychiatric symptoms were related to another medical or neurological condition. Only reports published in English were considered for inclusion. No restrictions on publication year were set.

Study screening progress was documented in a PRISMA flow chart[9] (Figure 1). After removing duplicates, our search strategy yielded 232 publications. Publications were then divided and screened by 3 reviewers (M.O., M.H., and R.K.) using Rayyan systematic review software[10] to determine if they met criteria for full-text review; 195 were eliminated because of irrelevance to the topic. Full-text screening of 38 articles was completed independently by the 3 reviewers

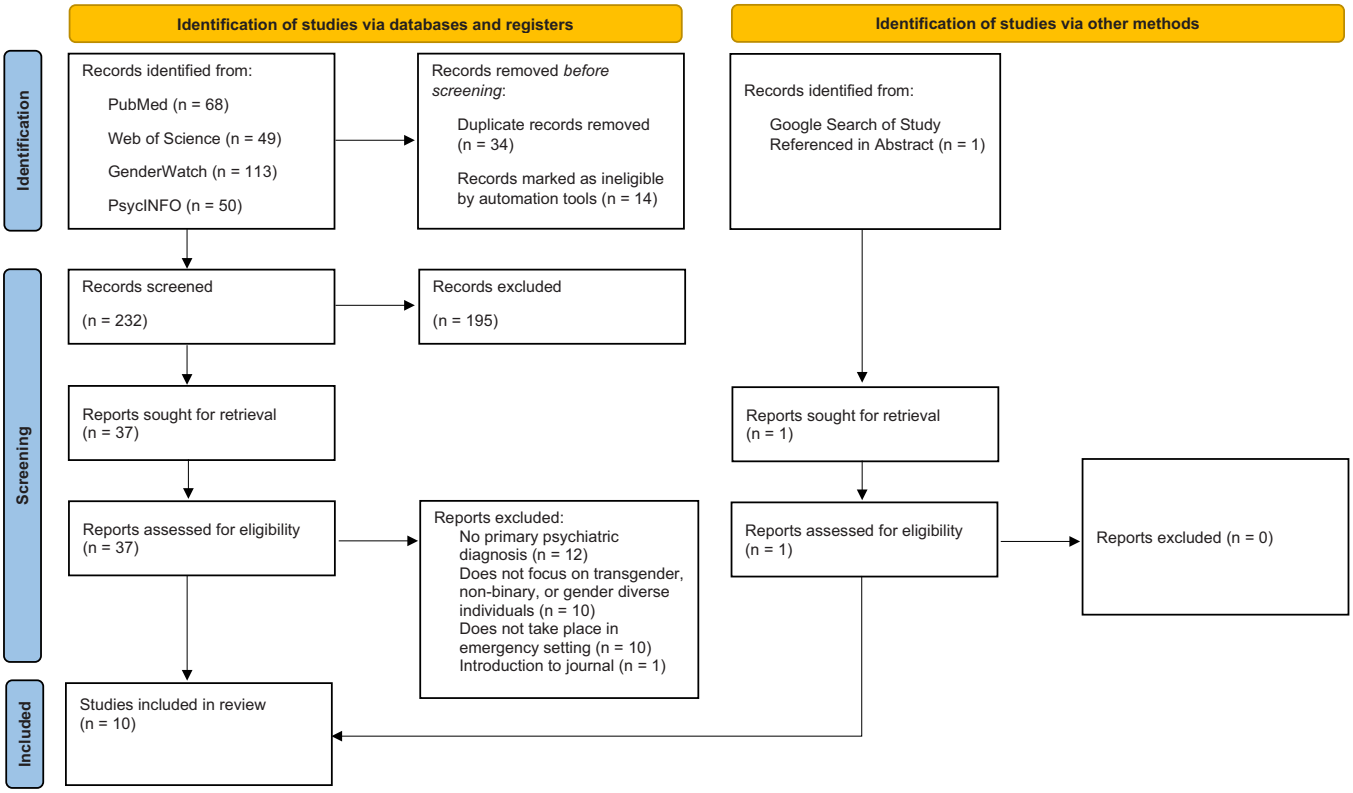

FIGURE 1 Preferred reporting items for systematic reviews and meta-analyses (PRISMA) flow diagram.

to determine eligibility for inclusion. Of the 38 full texts reviewed, 28 did not meet inclusion because they did not focus on transgender or gender diverse persons, they did not take place in the emergency setting, or they did not focus on a primary mental health concern. The 3 reviewers assessed and summarizing findings from the final 10 articles. Any disagreements in the full text review were resolved collectively by all 4 authors through consultation and detailed examination of the study. All authors met regularly to discuss any questions regarding the articles to ensure consistency in decision-making.

2.4 | Data extraction and synthesis

Data were initially extracted by the research librarian (P.T.) and then charted by the primary author (M.O.) into a standardized electronic form, including information about study design, funding source, study population, study location, study inclusion and exclusion criteria, and the main findings of each study. We performed a narrative synthesis because of heterogeneous study designs. No single summary measure was applicable across all studies.

2.5 | Data analysis

Modified versions of the Joanna Briggs Institute (JBI) Critical Appraisal Checklists[11] were used to critically appraise the included studies (Tables S3–S6). The JBI was modified to address specific areas relevant to the current scoping review (Tables S3–S6): text and opinion articles,[12] case reports,[13] analytical cross-sectional studies,[13] and cohort studies.[13] Three members of the review team (M.O., M.H., and R.K.) independently assessed each included study and resolved disagreements through discussion. Total critical appraisal scores ranged from 6 to 11, depending on the modified JBI tool used. Lower scores reflected lower methodological quality.

3 | RESULTS

3.1 | Characteristics of included studies

A total of 10 studies published between 2016 and 2023 met the inclusion criteria (Table 1). Of the studies included, 8 were from the United States, 1 was from Italy, and 1 was from Canada. Of the articles included, 4 were quantitative and/or qualitative studies, 3 were case reports, 2 were reflection pieces, and 1 identified best practices using a fictionalized case.

The participants in 2 of the quantitative and qualitative studies included adolescents and adults, and the other 2 only included adults. Of the 3 case reports, 2 focused on an adolescent, and 1 focused on an adult. The reflection pieces and fictionalized case report included adults. Most of the studies (n = 6) focused on emergency psychiatric services alone, and the remaining studies (n=4) focused on a variety of mental health clinical settings, including emergency psychiatric services. Of the studies included, 4 specifically included transgender

TABLE 1 Description of studies that met inclusion criteria.

Author and year	Study design and funding source	No. of participants	Study population	Age range (mean) of participants, years	Race/ethnicity of participants	Study location	Inclusion/exclusion criteria	Main findings
Berona et al. (2020)[18]	Cohort study. 4-month post-discharge phone interviews and 12-month chart review. Variables included LGBT status, gender nonconformity, interpersonal victimization, hopelessness, internalizing symptoms, alcohol use, suicidal thoughts and behavior, and non-suicidal self-injury. Stratified survival analyses.Supported by an Active Minds Emerging Scholars Fellowship, a Blue Cross Blue Shield of Michigan Foundation Student Award Grant, a University of Michigan Institute for Research on Women & Gender Community of Scholars Fellowship, and University of Michigan Rackham Graduate Student Research Grants.	285	42.1% male, 57.9% female, 2.5% gender minority, 41.8% sexual minority	13–25 (18)	7% Caucasian, 10% African American/Black, 4% Asian, 3% Hispanic, and 6% multiracial	Midwestern university hospital, USA	Not stated	LGBT participants reported more childhood gender nonconformity, victimization, hopelessness, and internalizing symptoms. LGBT youth more likely to endorse a lifetime history of NSSI and to report multiple episodes and methods. LGBT youth had a slower transition from NSSI to suicide.
Christensen (2020)[22]	Resident's reflections on queerness and countertransference in emergency psychiatry. Clinical scenario of resident's interaction with a transgender female. No funding sources disclosed.	N/A	N/A	N/A	N/A	Minnesota, USA	N/A	Narrative examines themes of paternalism, over identification with the patient, and identification with the perpetrator. Highlights call to expand influence from individual interventions to larger structural shifts.
Day et al. (2019)[16]	Clinical observation of an adolescent with gender dysphoria, severe body dysmorphia, and suicidal ideation who presented for emergency psychiatric evaluation. No funding sources disclosed.	N/A	N/A	N/A	N/A	Not stated	N/A	Gender dysphoria is a significant risk for psychiatric comorbidities, suicidal ideation, and suicide attempts. There is a connection between weight-related body dissatisfaction, suicidality, and gender dysphoria in adolescents. Explores early administration of cross-sex hormone therapy in case example.

(Continues)

TABLE 1 (Continued)

Author and year	Study design and funding source	No. of participants	Study population	Age range (mean) of participants, years	Race/ethnicity of participants	Study location	Inclusion/exclusion criteria	Main findings
Donnell (2022)[20]	Mental Health Acute Care Support Specialty Education Nurse in the ED's reflections on LGBTQIA+ patients presenting with mental health concerns. No funding sources disclosed.	N/A	N/A	N/A	N/A	Wellington, New Zealand	N/A	Identifies care considerations: non-judgmental and non-heterosexist attitude; nonbiased and inclusive language; confidential, safe environment; allowing patient's support network to be present; discreet distribution of resources around the department; and creation of LGBTQIA+ champions.
Donnelly-Boylen (2016)[17]	Case report of a 43-year-old transgender woman with serious mental illness presenting to the ED with genital self-mutilation in setting of an acute mood episode with psychosis. No funding sources disclosed.	N/A	N/A	N/A	N/A	Not stated	N/A	There is a need for further exploration of gender-affirming care restrictions in individuals with severe mental illness.
Fadus et al. (2020)[21]	Fictionalized case example of 22-year-old queer identifying individual as they move through acute psychiatric care setting (from the ED to the inpatient unit to discharge). No funding sources disclosed.	N/A	N/A	N/A	N/A	Not stated	N/A	Identifies best practices, such as affirming communication and cultural humility in history taking, risk assessment, treatment environments, and discharge considerations.

(Continues)

TABLE 1 (Continued)

Author and year	Study design and funding source	No. of participants	Study population	Age range (mean) of participants, years	Race/ethnicity of participants	Study location	Inclusion/exclusion criteria	Main findings
Lam et al. (2022)[3]	Cross-sectional study using linked health administrative data to compare characteristics of transgender individuals who had a psychiatric ED visit or a psychiatric hospitalization with characteristics of individuals in the general population of acute psychiatric care users. Used 2 comparison samples, 1 unmatched and 1 matched. Funding from annual grant from the Ontario Ministry of Health and the Ministry of Long-Term Care and from the Canadian Institutes of Health Research.	Transgender individuals with ED visit (N = 728); transgender individuals with hospitalization: (N = 454); unmatched comparison sample (N = 581,708); matched comparison sample (N = 2912)	Individuals age ≥16 who were discharged from a psychiatric hospitalization mental health–related ED visit (ED sample) in Ontario between January 1, 2012, and December 31, 2018	16 and older	Not stated	Ontario, Canada	Inclusion criteria: Index discharge (first discharge in time period) from ED or hospitalization for mental health care between January 1, 2012, and December 31, 2018; located in Ontario; age 16 or older. Exclusion criteria: not an Ontario resident; no valid health care number for data linkage; missing valid data for discharge diagnosis; age or area of residence does not match inclusion criteria.	Compared with the unmatched comparison group, transgender individuals were younger, experienced more marginalization, had different diagnostic patterns for their acute mental health care presentation, and had more prior mental health care utilization. Compared with matched comparison group, transgender individuals were more likely to live in lower-income neighborhoods and areas of greater residential instability and material deprivation. Compared with matched comparison group, transgender individuals were more likely to diagnosed as having mood or personality disorder, and less likely to be given substance use disorder or psychotic disorder. Transgender individuals in the ED sample were more likely to have presented to acute care for self-harm.
Morabito et al. (2021)[15]	Case report of a 15-year-old girl with gender dysphoria expressed as multiple somatic complaints. No funding sources disclosed.	NA	N/A	N/A	N/A	Not stated	N/A	In pubertal age, gender dysphoria can present as somatoform symptoms.

(Continues)

TABLE 1 (Continued)

Author and year	Study design and funding source	No. of participants	Study population	Age range (mean) of participants, years	Race/ethnicity of participants	Study location	Inclusion/exclusion criteria	Main findings
Progovac et al. (2018)[14]	Cross-sectional study looking at nursing facility, home health, carrier, and Part D event files. Uses Center for Medicare and Medicaid's high-specificity algorithm to identify gender minority patients in 2009—2014 Medicare claims, and compares them to a 5% random sample of non-gender minority beneficiaries on: mental health care use, preventive care, physical health hospitalizations, and ED use. Financial contributions from Harvard University and its affiliated academic health care centers.	Not stated	Gender minority individuals vs. 5% random sample non-gender minority individuals from Medicare claims in 2009–2014	Two age groups: disabled and under age 65 and age 65 and older; disabled eligibility gender minority individuals: 93% < 65, 6% 65–75, <1% 75–84, <1% 85+; disabled eligibility non-gender minority individuals: 74% < 65, 19% 65–75, 6% 75–84, 2% 85+; aged eligibility gender minority individuals: 0% < 65, 58% 65–75, 25% 75–84, 17% 85+; aged eligibility non-gender minority individuals: 0% < 65, 56% 65–75, 30% 75–84, 15% 85+	Disabled eligibility gender minority individuals: 73% non–Hispanic White, 16% Black, 8% Hispanic, 2% Asian/PI, 1% AI/AN, 1% other, <1% unknown; disabled eligibility non-gender minority individuals: 70% non-Hispanic White, 18% Black, 8% Hispanic, 1% Asian/PI, 1% AI/AN, <1% other, <1% unknown; disabled gender minority individuals: 73% non-Hispanic White, 16% Black, 8% Hispanic, 2% Asian/PI, 1% AI/AN, 1% other, <1% unknown; aged eligibility gender minority individuals: 88% non-Hispanic White, 4% Black, 4% Hispanic, 2% Asian/PI, 1% other, <1% AI/AN, <1% unknown; aged eligibility non-gender minority individuals: 84% non-Hispanic White, 7% Black, 5% Hispanic, 2% Asian/PI, 1% other, <1% AI/AN, <1% unknown	Not stated	Inclusion criteria: beneficiaries with continuous enrollment in Medicare parts A, B and not C for 12 months in each year studied. Exclusion criteria: beneficiaries with end-stage renal disease.	Gender minorities are more often under 65 and identify as White. Gender minorities are less likely to live in the South. Gender minorities are more likely to be dually eligible for Medicaid and Medicare. Gender minority beneficiaries had higher rates of mental illness and mental health utilization, and higher ED and hospitalization rates.

(Continues)

TABLE 1 (Continued)

Author and year	Study design and funding source	No. of participants	Study population	Age range (mean) of participants, years	Race/ethnicity of participants	Study location	Inclusion/exclusion criteria	Main findings
Romanelli et al. (2018)[19]	Secondary data analysis of Transgender Discrimination Survey was evaluated using structural equation modeling. Examined how experiences of service denial and discrimination in 3 health care settings—doctors' offices, EDs, and mental health clinics—might contribute to attempted suicide among transgender adults. No funding sources disclosed.	4190	Respondents to National Transgender Discrimination Survey; respondents had to identify as transgender and as a help-seeker	18 and over (37.9)	75.1% White, 24.3% non-White (Black/African American: 4.5%; Alaska Native: 1.3%; Hispanic/Latino: 3.1%; Asian/Pacific Islander 2.0%; Arab/Middle Eastern: 0.1%; multiracial: 13.3%)	USA, including Washington DC, Puerto Rico, Guam, and the US Virgin Islands	Inclusion criteria: identify as transgender; identify as a help seeker (attempted to access or accessed a doctor's office, ED, and/or a mental health clinic). Exclusion criteria: identified as gender-nonconforming or cross-dressers.	Denial of services and being discriminated against in more settings were associated with lower levels of treatment receipt. Service denial was correlated with increased rates of substance use and attempted suicide. Treatment receipt mediated the relationships between service denial and discrimination and substance use. Substance use mediated the relationship between treatment receipt and attempted suicide. Higher levels of support were protective when denied services in 1 setting, but not when denied in 2 or 3 settings.

Abbreviations: AI/AN, American Indian or Alaska Native; ED, emergency department; LGBT, Lesbian, Gay, Bisexual, or Transgender; NSSI, non-suicidal self-injury; PI, Pacific Islander; USA, United States of America.

participants, 4 included more broadly gender diverse participants, and the 2 adolescent case reports identified the patient's as having gender dysphoria, but did not directly state the gender identity of the patient.

Results from the studies reviewed were organized into 3 major categories based on the major themes that emerged from the literature. The first category was a broad identification of characteristics of TGD individuals in emergency psychiatric settings. The second category was identification of mental health vulnerabilities in TGD individuals. The final category included care recommendations and best practices for treating TGD individuals in emergency psychiatric settings. It is important to note that these results are based on the summation of the limited literature that exists on the topic, and in some cases summarizes data published from a single source.

3.2 | Characteristics of TGD individuals

TGD individuals presenting for emergency psychiatric services tend to be younger than non-gender diverse persons. In Lam et al.,[3] there was a statistically significant difference ($P < 0.001$) between the mean ages of transgender participants (28.8 years) compared to an unmatched general population (38.3 years). Progovac and colleagues' study of Medicare beneficiaries similarly found gender minority beneficiaries as significantly more likely to be younger than 65 (gender minority 93% vs. non-gender minority 74%, $P < 0.0001$).[14] Gender minorities were also found to be significantly less likely to live in the South (gender minority 27% vs. non-gender minority 42%, $P < 0.0001$)[14] or rural areas (gender minority 3% vs. non-gender minority 14.4%, $P < 0.001$).[3] Gender minorities were significantly found to live in a lower-income neighborhood (lowest quintile, $P < 0.001$) and with greater residential instability (highest quintile, $P < 0.001$) than non-gender minorities.[3] Progovac et al[14] also found that when compared with non-gender minorities, gender minorities were significantly more likely to be dually eligible for Medicaid and Medicare ($P < 0.0001$) and had significantly higher rates of mental illness and health care utilization ($P < 0.0001$).

3.3 | Mental health vulnerabilities in TGD individuals

In many of the included studies, mental health vulnerabilities within TGD individuals were elucidated. Multiple studies explored gender dysphoria and its presentation in emergency psychiatric settings. Morabito et al.[15] specifically explored a case study, which found that in pubertal aged individuals, somatoform symptoms may be the primary presenting problem for gender dysphoria. A connection between gender dysphoria and suicidal ideation and attempts also emerged. In their case study, Day et al[16] specifically discussed the connection between gender dysphoria, weight-related body dissatisfaction, and suicidality in adolescents. A call for further exploration on gender-affirming care restrictions in individuals with severe mental illness was brought forth in the reflection piece by Donnelly-Boylen.[17]

In addition to exploring gender dysphoria, multiple studies highlighted other mental health vulnerabilities faced by TGD individuals. Berona et al.[18] specifically explored non-suicidal self-injury (NSSI) and suicidal behaviors of LGBT youth receiving emergency psychiatric services. They found that compared with non-LGBT youth, LGBT youth were significantly more likely to endorse a lifetime history of NSSI episodes (LGBT 40.2 vs. non-LGBT 27.0, $P = 0.01$) and NSSI methods (LGBT 3.9 vs. non-LGBT 2.9, $P < 0.001$). However, LGBT youth showed a significantly slower transition (in years) from NSSI to suicide attempts (LGBT 4.0 vs. non-LGBT 2.6, $P = 0.05$). Berona et al[18] hypothesized this may indicate a higher reliance on NSSI as a maladaptive coping strategy for LGBT youth compared with non-LGBT youth.

Studies have also identified that compared to unmatched and matched samples, transgender participants were significantly more likely to experience internalizing symptoms or mood disorders.[3,18] Berona et al.[18] found that LGBT youth were significantly more likely to receive a mood disorder diagnosis (91.6%) than non-LGBT youth (80.7%) ($P = 0.01$). Lam et al.[3] found 26% of transgender participants, compared to 15.6% of the unmatched general population ($P < 0.001$) and 19% of a matched sample (matched by age, region of residence, and mental health care utilization history; $P < 0.001$), were diagnosed with a mood disorder. They also found that compared to the unmatched general population, transgender participants were significantly more often ($P < 0.001$) diagnosed with personality disorders (4% vs. 0.7%), schizophrenia or psychotic disorder (5% vs. 3.4%), and to present to emergency care for self-harm (7% vs. 5.2%), and less likely to be given an anxiety, trauma, or obsessive-compulsive–related disorder (38% vs. 46%), or a substance use disorder (14% vs. 25%).[3]

Romanelli et al[19] explored service denial in transgender individuals. The connection between service denial in health care settings with increased substance use as a coping mechanism (unstandardized $\beta = 0.037, P = 0.027$), and increased rates of attempted suicide (unstandardized $\beta = 0.044$, $P = 0.006$) in transgender participants was found to be statistically significant. Substance use also was found to significantly mediate the relationship between service denial and attempted suicide.[19]

3.4 | Care considerations for TGD individuals in emergency psychiatric settings

Another important theme that emerged out of the reviewed studies was the identification and implementation of best practices in providing care for TGD individuals in emergency psychiatric settings. The use of non-judgmental, affirmative, and inclusive language was described by care providers in 2 studies.[20,21] Fadus et al[21] further highlighted the use of cultural humility in all stages of acute psychiatric care, from history taking to risk assessment and discharge considerations. Christensen[22] reflected on an experience caring for a transgender woman and put forth the principles of paternalism and identification with these patients and/or their

TABLE 2 Critical appraisal ratings of studies that met inclusion criteria.

Author and year	JBI study type	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Total
Berona et al (2020)[18]	Cohort study	1	1	1	1	1	0	1	0.5	0	0	1	7.5/11
Christensen (2020)[22]	Text and opinion article	1	0.5	1	1	1	1	N/A	N/A	N/A	N/A	N/A	5.5/6
Day et al (2019)[16]	Case report	0.5	1	1	0.5	1	1	1	1	N/A	N/A	N/A	7.0/8
Donnell (2022)[20]	Text and opinion article	1	0.5	1	1	1	0.5	N/A	N/A	N/A	N/A	N/A	5.0/6
Donnelly-Boylen (2016)[17]	Case report	0.5	1	1	1	1	1	1	1	N/A	N/A	N/A	7.5/8
Fadus et al (2020)[21]	Text and opinion article	1	1	1	1	1	1	N/A	N/A	N/A	N/A	N/A	6.0/6
Lam et al (2022)[3]	Analytical cross-sectional study	1	1	1	1	1	1	1	1	N/A	N/A	N/A	8.0/8
Morabito et al (2021)[15]	Case report	0.5	1	1	1	1	1	1	1	N/A	N/A	N/A	7.5/8
Progovac et al (2018)[14]	Analytical cross-sectional study	1	1	1	1	1	1	1	1	N/A	N/A	N/A	8.0/8
Romanelli et al (2018)[19]	Analytical cross-sectional study	1	1	1	1	1	1	1	1	N/A	N/A	N/A	8.0/8

Abbreviation: JBI, Joanna Briggs Institute; N/A, not applicable.

perpetrators as important care considerations. This identifies the importance of health care providers identifying their own experiences and biases and being conscious of them when caring for this population.

In addition to changes on an individual level, Christensen[22] highlighted the need for expansion of interventions at a structural level in emergency psychiatric settings. Donnell,[20] another care provider, also supported structural change and discussed the need for confidential environments, rather than open spaces like a corridor, for triage and treatment of patients from the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual or Aromantic or Agender or Ally, and More (LGBTQIA+) community. Donnell[20] also encouraged allowing the patients to have a support system present throughout their care if the patient wants. Last, Donnell[20] also encouraged having resources discreetly distributed throughout the department and identifying an LGBTQIA+ champion within the ED.

3.5 | Critical appraisal of included studies

Most included studies demonstrated high methodological quality (Table 2). The critical appraisal had no impact on study inclusion or exclusion. One exception was for Berona et al,[18] which received a score of 7.5/11 due to missing methodological details. The funding source for each included study had no impact on the results.

4 | LIMITATIONS

This scoping review is not without limitations. First and foremost, there is currently a scarcity of literature in this field. Among the 10 articles identified, there was significant heterogeneity in the study designs. This led to more breadth, but less in-depth conclusions on the topic. Additionally, many of the articles reviewed used observational and subjective reporting, increasing the risk of lower methodological quality. Although we tried to use a variety of search terms, there is still the potential to have missed studies that did not fit with our terminology. One such example of this is the study by Surmaitis et al[23] that looked at toxicology consults in transgender patients. They found that the most common reason for the encounter was intentional self-harm. These consults were sometimes performed during their ED stay; however, our search terms did not pick up on this. Thus, although the article fits our topic, it was not included in our review.[23] Also, until recently, some databases did not look at gender identity, and only used dichotomous sex definitions, and thus would have been missed by our search. One such example of this is the ToxIC database, which did not add the term transgender until 2017.[23] Furthermore, we are limited by the lack of standardization in data collection when it comes to TGD individuals. For us to more accurately interpret the data and put forth care recommendations, better data collection are needed. For example, using a system such as the one being put forth by the National Academies of Sciences, Engineering, and Medicine for data collection may allow for identification of the needs of the TGD population.[24]

5 | DISCUSSION

This scoping review revealed that there is a huge lack of current data related to the topic of TGD individuals in emergency psychiatric settings. In our broad search of the current literature, we were only able to identify 10 studies that met our criteria. TGD individuals have a history of being marginalized by the health care system, and it is well documented that this population is faced with multiple negative mental health outcomes. This article highlights a current unmet need that requires further exploration.

Although it is hard to form strong conclusions with limited data, the current evidence available suggests 3 major themes within the current literature on TGD individuals in emergency psychiatric settings. The first major theme was the identification of characteristics specific to the TGD individuals seeking emergency psychiatric care when compared to non-TGD individuals. Specifically, TGD individuals were found to be younger, more likely to live outside of rural areas, and be at risk of experiencing other societal inequities like housing instability.[3,14]

The second major takeaway was that TGD individuals presenting to emergency psychiatric settings face a variety of mental health vulnerabilities. Compared to controls, TGD individuals were more likely to be diagnosed with mood disorders, personality disorders, or psychotic disorders.[18] They also have higher rates and methods of NSSI and suicide.[16,18] Transgender individuals were found to experience higher rates of service denial, leading to increased risk of suicide and substance use as a coping mechanism.[19] These results highlight the need for better emergency psychiatric care services and settings for these individuals. The scoping review's last theme looked at this specifically, and many of the articles we reviewed identified best practices for caring for this population. Among these were the importance of using of non-judgmental, affirmative, and inclusive language, and creating emergency psychiatric environments that are confidential, inclusive, and therapeutic for these individuals.[20–22]

This scoping review used a librarian to do an extensive search of current literature, looking at a wide range of databases (PubMed, Web of Science, GenderWatch, and PsycINFO). The librarian's search strategy was peer-reviewed by another independent librarian, and no revisions were recommended. The publications were imported into the systematic review software, Rayyan, and were reviewed by 3 authors. These reviewers then independently critically appraised the studies used the JBI Critical Appraisal Checklists.[11] To ensure consistency in decision-making, all authors met regularly to discuss disagreements and resolve questions that arose throughout the process.

Although this scoping review identifies that TGD individuals presenting to emergency psychiatric settings face unique mental health and societal challenges, there is still much to be learned on this topic. The scarcity of the literature on this topic demonstrates a gap in current mental health research and elucidates the need for more exploration on the experiences of TGD individuals in emergency psychiatric settings to better inform clinical practice.

AUTHOR CONTRIBUTIONS

MOB and PT completed the background literature search. MOB wrote the first draft of the article. All authors have approved the final article. Raj K. Kalapatapu, MD, PhD, will take final responsibility.

CONFLICTS OF INTEREST

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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